



STATE OF MICHIGAN

DEPARTMENT OF COMMUNITY HEALTH
LANSING

JENNIFER M. GRANHOLM
GOVERNOR

JANET OLSZEWSKI
DIRECTOR

July 1, 2006

TO: Interested Party

RE: Consultation Summary
Project #0608-Hospital

Thank you for your comment(s) to the Medical Services Administration relative to Project Number 0608-Hospital, Outpatient Prospective Payment System (OPPS).

Final policy related to the MDCH OPPS implementation will be released in a series of bulletins. The first bulletin, enclosed with this document, addresses coverage, processes, and other information necessary for the development/modification of claims submission and processing systems, as well as rate methodology-related policies that have been finalized. Subsequent bulletins will address other process and rate methodology/monitoring policies that have yet to be finalized. This document contains the comments and responses related to the initial policy bulletin, as well as the comments related to policy yet to be finalized. Responses to those questions will be provided with the release of the related final policy.

Comment: Requests to delay the implementation of the OPPS reimbursement methodology were received from both hospitals and health plans. Recommended delays ranged from six to nine months after the final policy is released.

Response: The implementation date for the MDCH OPPS has been changed to April 1, 2007. This date will allow sufficient time for hospitals and health plans to develop/procure software and processing systems necessary to submit and/or process claims under this new reimbursement methodology.

Comment: Numerous comments were received both for and against applying a hospital-specific wage index. It was also suggested that the Medicare wage index be applied rather than a Medicaid wage index.

Response: After consideration of the comments received and analysis of the impact of applying a hospital-specific wage index, the decision was made to not apply a hospital-specific wage. A wage index of 1.0 will be applied for all providers.

Comment: It was requested that the reduction factor not be applied to the outlier payment, since the calculated cost is already 50% of the cost of providing the service.

Response: The reduction factor will not be applied to outliers or any cost reimbursed items.

Comment: The policy should incorporate the formula that will be used to determine outlier payments in the policy and identify the portion of the payment that is from outlier so it can be adjusted to maintain budget neutrality.

Response: MDCH will utilize Medicare's outlier formula which is available in the Federal Register. For purposes of budget neutrality, MDCH will have access to outliers and will track them. The total outlier payment for each claim will be reported on the 835.

Comment: MDCH should not apply the reduction factor to services based on their pass through status or on the provider cost of the service.

Response: The reduction factor will not applied to outliers or any cost reimbursed items.

Comment: The fixed dollar outlier threshold should be removed or reduced to offset the artificially high threshold.

Response: The fixed outlier threshold will remain unchanged from Medicare. MDCH agrees with CMS as to target outlier reimbursement at no more than 3% of total reimbursement.

Comment: It was requested that MDCH develop a process to identify the outlier and pass-through payments to be able to determine if the amounts are reasonable or if deviations from Medicare's formula are needed.

Response: Outliers will not be reported at the claim line level, but will report on the 835 at the claim level.

Comment: Several comments were received requesting the Inpatient Only designated procedures list not automatically follow Medicare, or not be used at all.

Response: MDCH will implement its OPPS utilizing Medicare's Inpatient Only (IPO) list. Outpatient hospital paid claims data from 2005 was analyzed to determine the impact of implementing Medicare's IPO policy. A very small number of IPO services were identified and subsequently reviewed by the MDCH Office of Medical Affairs (OMA). Based on their review of the information, it was determined the Medicare IPO list was acceptable without change.

Comment: Use of Medicare's IPO List may result in elimination of Medicaid outpatient coverage for some services. It is requested that MSA determine if any outpatient procedures are impacted and adjust the IPO List if necessary.

Response: As stated above, OMA review of the results of applying Medicare's IPO list to Medicaid outpatient claims did not reveal any areas of concern.

Comment: The final policy should include a process to propose changes to the IPO list.

Response: MDCH routinely accepts and considers provider recommendations for policy changes. That practice will apply to proposed changes to the IPO list--no specific policy is necessary.

Comment: The final policy should state that patients with IPO conditions/services are automatically deemed qualified inpatients for any utilization review process the MDCH establishes and coverage by MCOs. We foresee MCOs requiring selected patients to be treated as outpatients by denying admission and no Medicaid outpatient payment existing because it is listed as IPO by MDCH.

- Response:** A blanket statement cannot be made that IPO conditions/services are automatically deemed qualified inpatients for UR purposes. If a review of medical documentation does not support the IPO condition/service billed, it would be appropriate to deny the admission. However, if the documentation does support the IPO condition/service, it would be the expectation of MDCH that the MCO pay the claim.
- Comment:** Adopting Medicare's IPO list will shift current treatment patterns to the more expensive IP setting.
- Response:** Review of Medicaid outpatient hospital paid claims does not support that statement.
- Comment:** A request was received that surgical procedures subject to discounting be set at 84% of Medicare screens to appropriately pay packaged services associated with these surgeries.
- Response:** MDCH will apply the Medicare discount logic to these services. The resulting amount will then be subject to the Medicaid reduction factor.
- Comment:** The proposed policy for bilateral procedures indicates the second procedure will be paid at 50%. This is not current Medicare policy; all are paid at 100%. Medicaid should be consistent with Medicare.
- Response:** The discount factor applies to bilateral procedures with a status indicator "T". MDCH will follow Medicare's payment policies related to bilateral procedures.
- Comment:** An analysis of the proposed APC rate at 58% of Medicare for lab, drugs, and biologicals indicates that the current Medicaid rates would be reduced by 23% for lab and 49% for drugs and biologicals—significantly below cost. MSA is urged to review proposed rates and consider different rates for these services rather than the 58% of Medicare rate.
- Response:** Analyses performed to determine budget neutrality included a stratification by service type. While some services will see a significant decrease, others will see a significant increase. However, across the specific service type, the overall impact is minimized, and any negative impact in one service area (e.g., lab) is offset by gains in another service area (e.g., surgical procedures). Positively adjusting the reduction factor for labs will adversely affect all other areas (surgical, pass throughs, etc.).
- Comment:** If the fee screen is greater than 58% (or final Medicaid reduction factor) of the Medicare fee screen, lab, drug and biological fee screens should be set at the current Medicaid fee screen. If the fee screen is less than 58% of Medicare fee screen, the Medicaid fee screen should be increased to match the Medicare fee screen.
- Response:** MDCH will apply the Medicaid reduction factor to the Medicare fee screens for lab, drug, and biologicals. The daily lab limit currently in place for outpatient hospital laboratory services is being removed.
- Comment:** MDCH should analyze the impact of applying the same reduction factor to lab and therapy payments. Medicare fees for these services are not set in the same manner as the APC amounts are. Automatically applying the same reduction factor may result in very different payment consequences from applying it to APC-based amounts. Rural hospitals may be impacted disproportionately from applying the same payment factor to non-APC based fees as APC based fees. MDCH should adjust the ultimate payment rates so this doesn't occur.

- Response:** These factors were considered when analyzing the impact of the OPPS reimbursement for these services. While some specific services within a category of service may experience a decrease, others may increase. The same is true for overall reimbursement to some hospitals. However, MDCH analysis indicates in aggregate the OPPS implementation will not result in discriminatory reductions to a specific type of hospital (i.e., rural vs. urban).
- Comment:** The reduction factor should not be applied to services paid based on their cost or pass through status. Addendum D of Medicare's rule identifies these services and has assigned them status indicators F, G, H, and K.
- Response:** The reduction factor will not be applied to cost reimbursed services with status indicator F or H that are not priced through the APC grouper.
- Comment:** MSA policy should clearly indicate whether self-administered drugs (revenue code 636) will be covered by Medicaid.
- Response:** Revenue code 636, billed with the appropriate value code(s), is covered for self-administered drugs administered in the ED when medically necessary (e.g., insulin injections for a diabetic in a diabetic coma).
- Comment:** It was requested that MDCH publish the process it will follow to insure that Medicaid fee screens stay in step with Medicare's.
- Response:** The OPPS policy states MDCH will implement changes in step with Medicare. That includes changes to codes, edits, and routine fee adjustments. These changes are provided as part of the MDCH's APC vendor's quarterly updates and will be incorporated into the MDCH claims processing system as quickly as possible upon receipt.
- Comment:** It is recommended that Medicaid provide coverage for all Medicaid beneficiaries determined by a physician to require observation care based on the McKesson InterQual observation criteria.
- Response:** MDCH observation coverage and reimbursement policy is being addressed separately from the OPPS implementation
- Comment:** The proposed observation room rate being set at 50% of Medicare's rate (approximately \$246.50 for 8 or more hours of observation care) is not acceptable. A payment rate of \$37 per hour is recommended.
- Response:** MDCH observation coverage and reimbursement policy is being addressed separately from the OPPS implementation.
- Comment:** Should hospitals begin reporting observation charges when OPPS are implemented, similar to the way we report observation charges to Medicare?
- Response:** MDCH anticipates implementation of a new observation coverage policy prior to the OPPS implementation. The claim completion instructions issued with the final observation policy will be consistent with APC billing requirements.
- Comment:** Please clarify the effective date for the OPPS. Will it be for specific date of services or date of submission.
- Response:** The OPPS will be implemented for dates of service on and after April 1, 2007.

Comment: When can APC test files be submitted?

Response: Business-to-business (B2B) test files may be submitted at any time and may be used for preliminary testing. However, MDCH will begin full B2B testing August 1, 2006.

Comment: Is there a specific timeframe test files must be sent in order to participate in the pilot program?

Response: To date, no specific timeframe has been established. However, all pilot hospitals must successfully complete B2B testing.

Comment: To facilitate testing, MDCH should provide a sample data set of claims with various kinds of services in the 837 format.

Response: MDCH will work with the health plans to facilitate testing of their processing systems.

Comment: MDCH needs to make rate manager files available for download in some generic format (i.e., CSV).

Response: MDCH will work with industry representatives to determine the best alternative to disseminate information.

Comment: How will the cutover of claims occur for dates of service prior to APC implementation? Will there be a transition period when claims with dates of service prior to implementation will be paid according to the current method and claims with a date of service after implementation will be paid with the APC reimbursement methodology?

Response: All provider type 40 claims submitted for dates of service on or after April 1, 2007 will be paid utilizing the MDCH OPPS payment methodology. All claims for dates of service prior to April 1, 2007 will be paid under the current MDCH outpatient hospital payment methodology.

Comment: What will be the timeframes for filing old claims under the current MDCH outpatient reimbursement methodology once the OPPS goes live?

Response: MDCH's one year billing limitation will apply. It is our intent to allow another 90 days (7/31/08) for providers to complete any necessary adjustments. No claims for dates of services prior to 4/1/07 will be accepted as of 8/1/08.

Comment: It is recommended the cost report settlement process include a calculation of the difference between payments that would have been made under the historical system and the OPPS, and a three year transition into the new payment system adopted. Providers should be reimbursed not less than 95% in year 1; 90% in year 2; and 85% in year 3.

Response: There will be no transition period with the MDCH OPPS implementation.

Comment: We support bringing hospital-based ambulance services under the same format as other hospital services. It will make billing more efficient. We request MDCH follow Medicare's process for ambulance and allow ambulance services to be billed on a separate claim from other services.

Response: MDCH will allow outpatient hospital ambulance services to be billed on a separate claim from other services provided on the same date of service.

Comment: Clarification of the repetitive/series billing under the MDCH OPPS is needed.

Response: MDCH will follow Medicare's guidelines for monthly repetitive/series billings. However, the current MDCH 50 service line limit will continue until the MDCH claims processing system replacement is completed.

Comment: Please clarify whether or not Medicaid will be paying for mammograms at the MDCH 58% reduction factor.

Response: MDCH will apply the reduction factor to the Medicare reimbursement rate for mammograms.

Comment: Cochlear implants should be added to the wrap around code list and policy established to monitor the completeness of the list.

Response: After analysis of paid claims data related to the cochlear implants for the past year, the decision was made to not include these devices in the wrap around code list. Based on the review, it was determined only 16 of the 40 claims paid during the past year would be significantly impacted by maintaining the policy as originally written, and these procedures will still pay more in the outpatient setting than if provided in the inpatient setting. The remaining 24 claims represented inpatient services not affected by OPSS or beneficiaries with Medicare coverage.

Comment: Request edit "051" be removed or changed and have any revenue code 450 that is not emergent be automatically switched to the lower clinic fee instead of getting a rejection and having to rebill. This doubles the handling by both MDCH and hospitals, wasting time and effort.

Response: Claims cannot be recoded. Inappropriate billings must be rejected and resubmitted as appropriate by the provider.

Comment: The impact file for Children's hospital included revenue code 821 (outpatient renal dialysis) as a packaged service with zero reimbursement. Please provide the correct impact for this revenue code service in your APC impact file.

Response: MDCH will reimburse series billed dialysis outside of the OPSS system by way of a wrap around code payment based on the HCPCS reported. Revenue code 821 is typically used for these services. The final list of wrap around codes and related rates will be posted to the OPSS project portion of the MDCH website.

Comment: Further explanation, with CPT codes and Medicare rates, is needed to clarify what the correct payment will be for Medicare non-covered services (e.g., sterilizations, abortions and well visits).

Response: The final list of wrap around codes and related rates will be posted to the OPSS project portion of the MDCH website.

Comment: MDCH should identify what portion of the payment is the pass through payment amount.

Response: The status indicator code published by Medicare identifies pass through payments.

Comment: The APC Workgroup should review all fee screen tables to assure the correct Medicare tables are being used to set the final fee screens for all APC services.

Response: The fee screen tables are supplied to MDCH by its OPSS software vendor as part of the annual/quarterly updates.

Comment: Please confirm that MDCH will publish the Michigan Medicaid fees and APC weights and rates (after discount factor). MHPs are concerned they will need to go to the Medicare website for Medicare fees, apply a discount factor and integrate codes and fees for non-Medicare covered services covered by Medicaid. A single fee schedule, updated on the same schedule as Medicare is needed to assure correct health plan payments to providers.

Response: MDCH will publish fee screens for wrap around codes. It will not publish APC weights, nor does it plan to publish Medicare fees with the reduction factor applied. MHPs purchasing APC software including quarterly updates, may be provided the Medicare fee changes through their APC vendor. To the extent that rate manager files can be shared, they will be made available as changes are implemented.

Comment: We support the establishment of new status indicators where Medicaid will not be following Medicare established rates. MDCH must maintain a single separate table of all CPT/HCPCS codes with the proper status indicator codes and payment rates (as is done for Medicare) that the public can access.

Response: MDCH will maintain a list of these wrap around codes on the MDCH website.

Comment: MDCH should conduct a special review for specific relative weights for moms/babies/pediatric services under APCs/OPSS.

Response: MDCH will implement its OPSS utilizing Medicare's weights, and will conduct post-implementation review of many variables such as payment trends, utilization, rates, reduction factor impact, overall expenditures, etc. to determine the need for OPSS modifications.

Comment: There has been a question as to whether the statement "58% reduction factor" means a 42% payment rate.

Response: The 58% reduction factor means MDCH will pay 58% of the Medicare calculated rate.

Comment: Will there be a release of policies for each individual edit?

Response: MDCH will not be releasing a policy for each individual OCE edit. In our current systems testing, MDCH is cross walking the OCE edits back to our MDCH proprietary edits and providers will not actually see the OCE edit on their claims/Remittance Advice. MDCH will provide a reference list of the MDCH Proprietary Edits that will apply under the proposed OPSS which will include a crosswalk to the corresponding OCE edit (if applicable).

Comment: Can you clarify whether the Health Plans are responsible for the Biweekly Interim Payments for services paid on a cost basis (section 10.10 in the Medicare Claim Processing Manual)?

Response: The items described in section 10.10 of the Medicare Claims Processing Manual - Ch 4. for Part B Hospital/OPSS do not apply under MDCH's proposed OPSS policy. These interim payments are for items that are not paid under the OPSS, but are reimbursable in

addition to OPPS and have to do with cost settlement and other special payment arrangements (i.e., medical education payments, bad debt payments etc.). MDCH currently has other payment processes in place for these special payments.

Comment: Would you consider the possibility of requiring hospitals to bill OPPS claims with Bill Types accepted under Medicare's version of OPPS? For example, a Critical Access Hospital would be required to bill with "131" as opposed to "851".

Response MDCH will require valid Outpatient Hospital Type of Bills to be billed under the proposed OPPS. This includes 13x, 14x, 34x, 72x, 74x, 75x, or 85x Type of Bills. Critical Access Hospitals should bill using Type of Bill 13x for their Fee For Service only claims and may bill with Type of Bill 85x on their Medicare dual eligible claims. In these cases where the provider bills with an 85x, we will have an internal systems crosswalk to change the TOB to a 13x before sending the claim onto the APC software.

Comment: Since critical access, children's hospitals, and some health plans have no experience with Medicare's OPPS, we are concerned that they are not familiar with APC billing requirements and will be required to do additional staff training and perhaps purchase new billing systems/modules.

Response: MDCH recognizes these entities may not be familiar with APC billing requirements and may require staff training and new/modified billing systems/modules. While they will be responsible for assuring their readiness to submit and/or process APC claims, MDCH is investigating training options to assist them in understanding APCs.

Comment: If the OPPS implementation is to be budget neutral, what is the point of having critical access hospitals going through the process of OPPS? They will have to become educated, rewrite policies, reengineer processing software—generally change their whole infrastructure and probably add new staff for no new money.

Response: MDCH currently uses the same methodology to reimburse for outpatient services provided by any hospital, including critical access hospitals. It will continue that practice under OPPS. The OPPS should alleviate many administrative burdens for both hospitals and MDCH by moving to a more standardized billing and reimbursement methodology for outpatient services. This implementation will also facilitate coordination of benefits and crossover claims which again will be beneficial to all parties involved. MDCH, hospitals and managed care plans will all have significant changes to be implemented under the proposed OPPS. However, the benefits of moving to this prospective payment system outweigh maintaining and continuing with our current billing and reimbursement methodologies for provider type 40s in light of the numerous challenges ahead.

Comment: Total reimbursement is limited to charges. Will this be the case for the implementation? Medicare guidelines state lesser of billed does not apply to APC methodology. If lesser of billed will apply to Michigan Medicaid APC, will it be based on claim line billed charge or will total claim billed charges be taken into consideration?

Response: MDCH will follow Medicare's methodology which does not apply lesser of logic for APC items or total charges. We will also follow Medicare and apply lesser of logic for fee schedule lines as well as our MDCH wrap around codes (ones that MDCH covers that Medicare does not).

Comment: Under Payment Calculation, Reduction Factor, the proposed policy states “the MDCH payment will be the lesser of: the second option reads to say items from the fee *schedule* will be limited to the charge, where no such limit applies to fee *screen* items in the first option. Is this true for all fee schedule times or only in specific instances, such as when another insurance has made a payment? Our interpretation assumes there is a difference intended between the terms, where fee schedule refers to amounts determined by the Medicare non-APC Payment Schedules, such as lab. The MDCH policy should follow Medicare and not limit payments to the charges as well as for either fee screen or fee schedule items. It should also better define the intended distinction between fee screen and fee schedule and which payment option applies.

Response: The “lesser of” logic applies to services/items that are not grouped under an APC or paid on a cost-to-charge basis.

Comment: It is important that MSA ensure all MHPs implement edit/code and reimbursement rate changes consistent with Medicare/Medicaid policy changes at the time so all Medicaid claims can be prepared and processed in a consistent manner. Request that MDCH have a plan to closely monitor all Medicaid payers for consistency in claims processing.

Response: MDCH monitors all MHPs by requiring submission of monthly reports, indicating if they are making timely payments. The MHPs accept electronic billing, use the proper forms and adhere to uniform billing. They may, however, ask for documentation that MDCH does not require, and/or utilize prior-authorization when FFS does not, which will remain up to the discretion of the MHP.

The following comments/questions were also received and will be addressed in a separate consultation summary accompanying subsequent OPPS-related bulletins.

Comment: A new policy proposal with comment period should be issued that outlines clearer specifications related to the plan to evaluate and maintain budget neutrality (monitoring of budget neutrality, reduction factor adjustment, and specific process that will be used to ensure budget neutrality will be accomplished). MSA is encouraged to use actuarial projections on the FFS claims base to set the initial discount factor and then a final adjustment applied based on actual FFS claims processing experience in conjunction with actuarial analysis that would be applied for claims paid on or after OPPS implementation.

Comment: It is unclear how MSA intends to adjust the Medicaid fee screens when Medicare APC rates are updated. Unless new funds are appropriated, this annual update will likely result in a decrease to the conversion factor each year, increasing the disparity between Medicare and Medicaid payments.

Comment: The initial budget neutrality factor should be calculated by MDCH and communicated to providers at least 45 days prior to the start of the period that the OPPS implementation.

Comment: Budget Neutrality/Reduction Factor – policy should describe what data will be used to evaluate budget neutrality; how increases in projected case load will be factored into the calculation, when the adjustment will be made; and how adjustment to reach budget neutrality will be paid to MDCH or the provider.

Comment: Predictability and administrative simplicity are not enhanced by creation of an ongoing set of complicated calculations and adjustments to the discount factor. Claims paid by entities other than MSA and for non-Medicaid services (e.g., MHP and Adult Benefit Waiver claims) should be excluded from the budget neutrality determination process.

- Comment:** The proposed policy states all APC reimbursement rate changes will be made in step with Medicare. Therefore, in accordance with this statement, all inflationary updates with the Medicare APC rates will be include in Medicaid APC fee screens.
- Comment:** By setting Medicaid payments at a percentage that is less than the co-insurance factor of 20% on Medicare, it should eliminate all or nearly all such payments by Medicaid. These appropriated funds need to remain in the Type 40 pool of funds when comparing for neutrality.
- Comment:** It is apparent MDCH has and will continue to recover Type 40 funds from the MACI program. These recovered funds should remain in the Type 40 unless another method of redistribution to hospitals is made for these recovered amounts.
- Comment:** The OPPS transition should not result in a shifting of funds out of dialysis or CORF providers to hospitals. Request that MDCH adjust fees so no loss in payment occurs for dialysis providers, since there are virtually no insurers outside of Medicare and Medicaid from which to recover lost payments for these services.
- Comment:** A new financial analysis should be done using a broader data set, making the results and data available to hospitals. The new analysis should also be done that identifies the financial impact by procedure.
- Comment:** How could anyone ethically support the proposed OPPS payments? Someone needs to do a better job calculating the reductions. If the final dollar results in a massive underpayment (remember budget neutral), we need to be paid the difference in a lump sum.
- Comment:** A state law mandates that Medicaid FFS outpatient payments (including MACI payment, GME, etc.) to an individual hospital cannot exceed the cost calculated based upon the hospitals fiscal year. The uncertainty in outpatient reimbursement that will result from this policy and conversion factor will make provider projections of annual FFS revenue and costs extremely difficult. At a minimum, the cost limit should be removed or modified to represent an average of hospital costs cover a two year period. The cost limit should be removed or modified to represent an average of hospital costs over a two year period.
- Comment:** Critical Access Hospitals should be removed from OPPS.
- Comment:** Transition should not result in shifting of funds out of rural area providers to urban ones.
- Comment:** Request cost report settlement process include a calculation of the difference between payments that would have been made under the historical system and the OPPS.
- Comment:** MDCH needs to fully understand the financial implications to the MHPs. There has not been enough analysis of the regional impact in the changes for hospital reimbursement. Cost of administrative burden, IT, and claims department resources, procurement of software and payments to providers must be included in rate development discussions with MDCH for FY 07.
- Comment:** Any changes in enrollment for ambulance services, that go beyond notification by letter that the ambulance service will be switching from the professional billing format to the institutional billing format, should be automatically processed by MDCH.

I trust your concerns have been addressed. If you wish to comment further, send your comments to Susan Schwenn at:

Medicaid Policy Division
Medical Services Administration
P.O. Box 30479
Lansing, Michigan 48909-7979

Sincerely,

A handwritten signature in black ink, appearing to read "Susan Moran". The signature is fluid and cursive, with a long horizontal stroke at the end.

Susan Moran, Acting Deputy Director
Medical Services Administration